Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5206AGC	A. BUILDING _____ B. WING _____	02/06/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUALITY GUEST HOME	5280 BURNHAM AVE LAS VEGAS, NV 89119

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on 02/06/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 5 Residential Facility for Group beds for elderly and disabled persons, persons with chronic illness, and persons with mental illness, Category I residents. The census at the time of the survey was 4. One discharged resident file was reviewed and zero employee files were reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. Complaint #NV00020866 was substantiated. See Tag #851. The following deficiency was identified:	Y 000		
Y 851 SS=D	449.274(1)(b) Medical Care of Resident NAC 449.274 1. If a resident of a residential facility becomes ill or is injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (b) Request emergency services when such services are necessary.	Y 851		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 851	Continued From page 1 This Regulation is not met as evidenced by: Based on interview and record review, the facility failed to notify a resident's public guardian regarding an ambulance transport to a hospital (#1). Findings include: On 2/06/09 in the morning, a friend of the facility's owner indicated Resident #1 was engaged in a phone call with his sister on the morning of 1/30/09. Shortly after hanging up with his sister, an ambulance arrived to take Resident #1 to a local hospital. Resident #1 never indicated reasons he needed an ambulance to the owner's friend or the caregiver. The owner's friend and the caregiver present indicated they were told only the name of the hospital before the ambulance left with Resident #1. They never heard back from the hospital, never returned messages left by the public guardian, and never informed the public guardian about the resident's transport to the hospital. Resident #1's file lacked documented evidence regarding notification of the public guardian. Cpt: #20866 Severity: 2 Scope: 1	Y 851		